Maricopa County
RETIREES
Enrollment / Change Form

Please Print

Last Name	First Name	MI

Reason For Completing Form

		Please Mark One
◉ New Retiree Retirement Date: ___/___/_____ ○ COBRA Coverage Expiration Date Ended: __/___/____ ○ Cancel Coverage as of __/__/____ ○ Medical & Dental ○ Dental Only *Re-enrollment is not permitted after cancellation of coverage.*	○ Open Enrollment ○ Became Medicare Eligible *Please attach a copy of your Medicare card* ○ Add Dependent Coverage ○ Cancel Dependent Coverage ○ Other Please explain: _____ _____	◉ ASRS Retiree ○ PSPRS Retiree ○ EORP Retiree ○ CORP Retiree ○ PORP Retiree

Retiree Medical Plan Options

◉ HMO CMG High Option ○ HMO CMG Low Option ○ OAP In-network	○ OAP High Option ○ OAP Low Option ○ CIGNA Medicare Select Plus Rx (Must be enrolled in Medicare Parts A & B and reside in Maricopa County)

Spouse &/or Dependents Medical Plan Options

◉ CIGNA Medicare Select Plus Rx (spouse only)
○ CMG (if spouse is on CIGNA Medicare Select Plus Rx)
○ Same plan as retiree (Spouse &/or family)

Pharmacy Plan Options

Must Choose One To Accompany Medical Plan except for CIGNA Medicare Select Plus Rx.	◉ Co-Insurance Plan	○ Consumer Choice Plan

Dental Plan Options

○ Decline Dental	Note: You Must Be Enrolled in a County Medical Plan to Elect Dental			
◉ Employers Dental Services	○ CIGNA Dental	○ Delta Dental		
Dental Level of Coverage:	◉ Retiree	○ Retiree & Spouse	○ Retiree & Child(ren)	○ Retiree & Family

Retiree Demographic Information

Social Security # (voluntary)	Employee ID# 81	Requesting Alternate ID #? ☐ No ☐ Yes (Must submit Alt. ID Request Form) Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Medicare Information: ☐ Do not have Medicare ☐ Have Medicare Part A &/or B *Please attach a copy of your Medicare card*	Date of Birth	Gender ○ Male ○ Female

Mailing Address	City	State AZ	Zip

Email Address	Home Phone #	Cell Phone #

Contact Name	Contact Phone #	Contact Address

Return to: Maricopa County
Employee Health Initiatives Department
301 W Jefferson, Suite 201
Phoenix, AZ 85003
Phone: 602-506-1010
Fax: 602-506-2354

Revised April 22, 2008

Dependent/Beneficiary Section

Eligible dependents who can be covered under your plan include your:

- Legal spouse
- Child under age 19
- Your unmarried child, of any age, who resides with you and is medically certified as disabled prior to his/her 19th birthday or prior to age 25, if disabled while a full-time student.
- Your unmarried child between the ages of 19 and 25 who is a full-time student at an accredited institution of higher education and is dependent upon you for support or maintenance (you must provide more than 50% of his/her support). You must supply 3rd party documentation from the school showing student status.

Dependent/Beneficiary Information

Enroll Eligible Dependent for ☐Medical ☐Medical & Dental Plan	RELATIONSHIP	☐ Legal Spouse ☐ Child (under 19)	☐ Stepchild (under 19) ☐ Full-Time Student (19 and older)	☐ Handicapped Child ☐ Legal Guardianship
Social Security # (Voluntary)	Last Name	First Name	Date of Birth	GENDER ☐ Male ☐ Female
Mailing Address ☐ Same as retiree's		City	State	Zip
Medicare Information	☐ Do not have Medicare	☐ Have Medicare Part A &/or B *Please attach a copy of your Medicare card*		

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Social Security # (Voluntary)	Last Name	First Name	Date of Birth	GENDER ☐ Male ☐ Female
Mailing Address ☐ Same as retiree's		City	State	Zip
Medicare Information	☐ Do not have Medicare	☐ Have Medicare Part A &/or B *Please attach a copy of your Medicare card*		

Additional plan forms and provider information are available online via the Internet at: http://www.maricopa.gov/benefits/retirees.aspx

Once your plans go into effect, you must have a "Qualified Status Change" as defined by the IRC Section 125 in order to modify your Medical or Dental plan elections. Information about qualified status changes can be found in the *Know Your Benefits* guide. It is your **responsibility** to submit the change request form to the Employee Health Initiatives department and attach appropriate 3rd party documentation of the qualifying event within 30 calendar days of a status change.

Authorization

By submitting my open enrollment request or continuing with my current health care coverage, I understand and agree that Maricopa County may share protected health information (PHI) concerning me and my dependents, as described in the Maricopa County Notice of Privacy Practices, with my health care providers which could include CIGNA HealthCare of AZ and CIGNA Dental, Walgreens Health Initiatives (WHI), Magellan Health Services, Delta Dental, Employers Dental Services (EDS) and EyeMed Vision Care. I further agree to release Maricopa County and Maricopa County's health care providers from any liability for any good fait release of PHI in connection with my benefits or as otherwise authorized or required by law.

I acknowledge and agree that I am responsible for and will pay the full amount of any premiums due regardless of receipt of subsidy from any qualifying Retirement System, such as ASRS or PSPRS. This means that if the applicable state retirement system fails to pay its premium subsidy, I am responsible for the entire premium amount due. I understand that failure to pay the full premium amount due for any reason may cause termination or interruption of my health insurance benefits and I further understand and agree that I will be liable and responsible for all claims incurred during such periods of non-coverage caused by non-payment of premiums.

I certify to the best of my knowledge all information I have provided is accurate, correct and complete.

Retiree Signature: _____ Date: _____

For Office Use Only:

Effective Date: Monthly Premium: $ Coverage Code:
Validation